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ABSTRACT

As one of a series of topic papers assessing federal laws and programs affecting persons with disabilities, this paper outlines several ways in which existing Social Security laws serve to discourage and penalize people with disabilities if they seek to become employed and self-supporting. Programs funded under the Social Security Act are described, including Supplemental Security Income (SSI), Medicaid, Social Security Disability Insurance (SSDI), and Medicare. The disincentives to work which are found in these programs are then detailed. These disincentives include, among others, the reduction of SSI or SSDI benefits and the loss of income security when a recipient returns to work, and the lack of private health insurance for people with disabilities, forcing them into income support programs. Two case studies demonstrate successful experiences associated with a federal program which allows employed workers with disabilities to continue receiving Medicaid benefits for disability-related expenses. A third case study illustrates the work disincentive that results when a person with disabilities who has vocational potential is automatically eligible for income support payments. Costs and benefits associated with removing the work disincentives in current programs are explored, and recommendations are made to correct provisions of existing Social Security laws. (JDD)

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TOPIC PAPER C:

DISINCENTIVES TO WORK UNDER SOCIAL SECURITY LAWS

National Council on the Handicapped

February, 1986

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I. INTRODUCTION

In this paper, the National Council on the Handicapped explores the extent to which the income and medical benefit programs authorized under the Social Security Act encourage disabled people to become self-sufficient and gainfully employed. These programs provide many severely disabled people with basic life necessities. However, consumer and service provider experiences indicate that some program provisions encourage dependence and discourage gainful employment. As a result, the Council finds that the multibillion expenditure for these programs is not cost-effective. Over the long run, these program expenditures will be reduced if the programs are modified to reflect the fact that many severely disabled people have the ability to become gainfully employed.

The Council recognizes that disincentives to work result from the combined effect of many policies and programs. However, the Council is focusing this paper on disincentives to work within the Social Security Income (SSI), Social Security Disability Income (SSDI), and related medical benefit programs because of the extent of their influence on disabled people.

II. PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT

The Social Security Act authorizes the income support and medical benefit programs which provide the basic necessities of life for many severely disabled people, as well as the only hope for a comparatively independent existence. The following sections briefly describe Social Security Income (SSI) and associated benefits under the Medicaid program, and Social Security Disability Income (SSDI) and associated benefits under the Medicare program.

A. Supplemental Security Income (SSI, Title XVI of the Social Security Act)

Supplemental Security Income is a federally-funded and State-administered program that pays a monthly cash benefit to disabled, blind and elderly persons with limited, intermittant or no work history and limited incomes and assets. Under some conditions, SSI payments are made to disabled children. Persons eligible for SSI benefits are usually referred for Medicaid medical insurance coverage. In 1985, the basic Federal SSI payment for an eligible single adult or child was $325 a month; $488 for an eligible couple. About half of the States supplement this amount (Committee on Ways and Means, 1985, p. 432). In January of 1985, the maximum potential SSI benefits for individuals ranged from $325 to $586 (Alaska); the average yearly SSI benefit in 1984 for an individual was $3,768, or 76% of the poverty threshold (Committee on Ways and Means, 1985, p. 435-446).

Eligibility for SSI disability benefits is dependent upon medical proof of a severe disability expected to last at least 12 months. In Fiscal Year 1984, 2.435 million blind or disabled persons under the age of 65 received SSI benefits. Total Federal Fiscal Year 1984 program costs for the SSI program were $8.5 billion; disabled people represented about 60% of all beneficiaries.

B. Medicaid (Federal-State Medical Assistance Program, Title XIX of the Social Security Act)

Medicaid is a federally funded program of primary and long term medical care for indigent and disabled people. Medicaid pays for health care expenses and other services such as personal care attendants, therapy, and disability-related (prescription) medical supplies.

Medicaid is administered by the States, which have considerable leeway in determining eligibility criteria and benefit levels. States must cover all persons receiving benefits under Title IV-A of the Social Security Act (Aid to Families with Dependent Children, AFDC) and, generally speaking, those who receive SSI benefits. Some States also provide coverage for persons with low incomes who cannot afford medical assistance. Because each participating State has broad flexibility in designing a Medicaid program, the programs differ greatly from State to State.

In Fiscal Year 1986, an estimated $12 billion (of a total estimated Medicaid expenditure of $25 billion) will be expended by the Federal and State Governments in Medicaid payments for disabled and blind individuals. Of this amount, approximately 35% will pay for Intermediate Care Facilities for Mentally Retarded (ICF/MR) persons. Approximately 10% of all Medicaid clients are disabled or blind. (Social Security Bulletin, 1985; Catalog of Federal Domestic Programs, 1985.)

C. Social Security Disability Insurance (SSDI, Title II of the Social Security Act)

The Social Security Administration provides monthly disability income benefits to workers who meet the insured status requirement (work at a certain level for a specified number of years) and who are determined to be disabled. Disability benefits may also be paid to a disabled adult (over age 18), children

of a deceased, disabled, or retired eligible worker, and to disabled widows (of formerly eligible workers) who are over the age of 50 and who meet specific medical standards.

Earned work credits are used to determine whether an individual meets the status requirement. The credits vary according to the person's age before onset of the disabling condition. In general, workers over the age of 30 need at least 5 years of work credits in the 10 years immediately before onset of disability in order to be eligible for SSDI benefits. SSDI benefit payments are based on the worker's lifetime average earnings that were covered by Social Security.

SSDI benefits are paid from a special trust fund that is financed by Social Security taxes. Eligibility for SSDI payments requires proof that the individual is unable "to engage in any substantial gainful activities by reason of a medically determinable physical or mental impairment which has lasted or can be expected to last for 12 months or to result in death."

Section 202(d) of the Social Security Act requires that all applicants for, and recipients of, SSDI benefit programs be referred to the State vocational rehabilitation agency if they are considered likely to benefit from services. The screening process is based on criteria established jointly by Vocational Rehabilitation and Social Security.

Although the disincentives to employment described below may affect the success of the Beneficiary Rehabilitation Program (BRP), no one knows what percentage of SSDI recipients would actually become employed under an "ideal" system. However, a study conducted by Rutgers of 1973 beneficiaries found that employment rates were highest among comparatively well educated, young male recipients of benefits (Berkowitz, 1980). Current statistics provide a limited perspective on prospects for employment among SSDI beneficiaries: In 1982, 47% of disabled SSDI beneficiaries were over age 54 (as compared to 32% of the adult

U.S. population), and 27% had less than a high school education (as compared to 19% of the adult U.S. population). Circulatory, skeletal-musculo and neoplasms accounted for 58% of the disabling conditions; 81% of SSDI recipients were ambulatory outside of the house without assistance. (Committee on Ways and Means, 1985, p. 113-115.)

The average monthly SSDI income benefit for a disabled worker in early 1985 was $449; the average payment to a worker with a family was $893. In 1984, 2.6 million workers received benefits, or about 3.4 persons per 1,000 employed workers. The addition of dependents brings the total number receiving SSDI benefits to 3.8 million. Approximately $18.1 billion in benefits were paid out in Fiscal Year 1985. (Social Security Reference Guide, 1985.)

D. Medicare (Title XVIII of the Social Security Act)

Disabled workers who are eligible for SSDI receive Medicare hospital insurance after they have been entitled to monthly disability checks for 24 months. Medicare assists in the payment of inpatient hospital care and certain types of short term follow up care, including short term home health aides and homemaker services. An additional, voluntarily obtained Medicare program pays the costs of physician services and other medical items not covered under the Medicare Hospital Insurance program. The monthly cost in 1985 for this coverage is $15.50. Individuals who require on going medical supplies and personal care assistance obtain services under Medicaid after qualifying through "spend down" procedures: applicants must document that their medical expenses reduce their monthly income below the Medicaid eligibility income ($370 in 1985) over a six month period.

In 1984, almost 2.9 million disabled persons received Medicare hospital (Part A) insurance protection at an annual benefit payment per disabled person of

$1,643. Benefits were used by 770,000 beneficiaries. Part B supplemental coverage was purchased by 2.66 million disabled beneficiaries; 1.9 million persons received an average reimbursment of $1,545 for medical services obtained under Part B. (Ways and Means Committee, 1985, p. 123.)

III. DISINCENTIVES TO WORK

Although Congress has changed the Social Security legislation to reduce disincentives to work, disincentives remain in the program. This section discusses the nature of these disincentives and briefly identifies other constraints on the ability of a disabled person to obtain employment.

A. Eligibility for the SSI and SSDI Programs is Based on Inability to Work

By definition, eligibility for SSI disability benefits or SSDI benefits is based on the assumption that disabled beneficiaries are unable to work. In principle, a person who is able to work should not be entitled to disability benefits.

However, disabilities obviously cannot be categorized simply as those that prevent one from working and those that do not. Many persons with severe medical impairments are able to accept some type of employment. For example, a person with a spinal cord injury might be able to work full time for several years following rehabilitation after the onset of injury until disability-related medical problems force him or her to stop. Another person with a similar disability might be able to work twenty hours a week for many years; another might not be able to work at all. Similar differences occur among persons with developmental disabilities, particularly if individuals have multiple disabilities.

Currently, individuals with certain specified medical diagnoses (e.g., deafness, blindness, quadriplegia) are automatically considered eligible for SSI and SSDI disability income benefits unless they have a substantial work history after the onset of disability. For those without such clear medical diagnoses (e.g., persons with severe back pain, some types of cancer and mental illness),

the deciding criteria becomes the duration of disability (at least 12 months duration) and the inability to work. In some instances as much as a year's time may elapse if an individual and his or her lawyer and family contest the disability determination findings. The emphasis on inability to work in the application process can have destructive effects on the applicant's morale and willingness to try to return to work.

The automatic assumption that a person with a severe disablity cannot work also creates problems. In particular, automatically providing income benefit payments to a severely disabled young person who could develop work skills can destroy the incentive to become self-sufficient. For this reason, some disabled individuals argue against automatic eligibilty for SSDI and SSI benefits on the basis of disability.

Ability to work is dependent upon a large number of variables, including training, dexterity, physical strength, attitudes and competencies, and economic conditions. In fact, many severely disabled people have both the ability and the desire to work, but face substantial barriers to employment. This is particularly true for an individual who cannot earn enough to cover the cost of high disability-related expenses that are covered as part of their eligibility for SSI or SSDI. Such individuals cannot afford to lose the medical benefits associated with income support payments--they literally cannot afford to work. However, employment is an essential key to successful adult integration into community life. Various forms of work are associated with greater independence, productivity, self-esteem, social status and financial security. Success and quality of life are often measured in terms of paid employment, and work is an important component of each individual's right and obligation to live as independently and as responsibly as possible in the community. Defining

disability as the inability to work denies disabled individuals the opportunity to reach their full potential as contributing members of society.

B. A SSI or SSDI Recipient Who Returns to Work Usually Faces a Reduction if Not Loss of Income and Benefits

Many disabled people want to work but cannot risk losing their medical benefits. Some disabled persons, such as spinal cord injured individuals, require disability-related medication, supplies, personal care attendant services, and equipment throughout their lifetimes. Often these expenses cannot be paid by a disabled person with the typically low income associated with most entry level jobs. In addition, few private insurers offer medical insurance coverage for preexisting conditions.

The potential loss of employment threatens the hard-won independent lifestyle of many of these individuals. Their work choices are more limited than those available to their nondisabled counterparts, so a job loss often means long periods of unemployment. Furthermore, reentry into income support programs is often arduous and time consuming, a threatening prospect for an individual with extensive requirements for ongoing medical services. For these reasons, employment may not be a cost-effective option for some disabled individuals if it means the loss of medical benefits.

However, there is some evidence that employment helps individuals stay well. The Allied Health Program at Boston University recently compared the health of employed and unemployed persons with severe disabilities (Conversation with Project Analyst, 7/8/84). Their findings support the statement that, in general, disabled people who are employed require medical attention less frequently than unemployed individuals.

The total benefit and income loss or gain must be considered when a disabled person who receives public benefits goes to work, including the loss of income

support, medical care coverage, and social services. The potential income loss is particularly striking in the SSDI program. Beneficiaries who returned to work in 1984 and earned the substantial gainful activity (SGA) wage of $300 per month or more--about three-fifths of the minimum wage for a full-time worker--were allowed a nine month trial work period if they returned to work. At the end of the trial work period, they were re-evaluated. If thought capable of earning over $300 per month, the individual was terminated from SSDI. However, there is little incentive for a SSDI recipient to work for a salary of $300 per month. Total benefits are usually higher than $300 per month, especially when the individual has dependents or has high disability-related medical and transportation costs.

Continuation of health benefits may be as important to a disabled person as income support payments, especially if ongoing medical services, supplies and personal care attendant services are needed. Prior to 1981, SSDI beneficiaries who lost their entitlement to cash benefits also lost their entitlement to Medicare. Beginning in 1981, however, Congress changed the law so that SSDI beneficiaries who lose their entitlement to cash benefits can continue to be eligible for Medicare or Medicaid (spend down) benefits for 36 months. Because of the three year time limit on this provision, and the difficulty of obtaining private health insurance coverage, this provision reduces but does not eliminate this source of work disincentive.

Also in 1981, Congress attempted to eliminate some of the major disincentives from the SSI program through the Section 1619 demonstration program. Section 1619(a) authorizes special cash benefits as long as the SSI recipient's earnings are below the Federal break even point--$735 for an individual in 1985. The other special demonstration, incorporated as Section 1619(b) of the Social Security Act, continues Medicaid coverage for SSI

recipients who return to work. Coverage can continue even if cash benefits terminate when earnings exceed the Federal breakeven point, provided that the recipients 1) continue to qualify on the basis of limited assets, 2) would not be able to pay for medical benefits equivalent to Medicaid, and 3) would have difficulty maintaining their employment without such coverage.

These demonstrations have been underutilized, however, because until recently little information about the demonstration was disseminated to recipients and Social Security personnel, and partly because the program is very complex. According to Patricia Owens, the Associate Commissioner for Disability in the Social Security Administration (1985), in August of 1984 just 406 individuals received Medicaid coverage through the special cash benefits provision of Section 1619. Another 6,804 individuals retained their Medicaid eligibility although they received no cash benefits. The average earnings of recipients of the special cash benefit were $464 per month, allowing an average Federal monthly payment of $127. The average earnings of Section 1619 participants who retained only Medicaid were $666 per month.

The Social Security Disability Reform Act of 1984 (Public Law 98-460) extends Section 1619 (a) and (b) to 1987. It also requires the Secretaries of the Department of Health and Human Services and the Department of Education to train their own staff and to inform SSI applicants, recipients and concerned public and private agencies and organizations about the provisions of Section 1619.

By mid-1986, data is to be collected by the Social Security Administration and the Health Care Financing Administration about the characteristics of the individuals benefiting from Section 1619, the effects on work efforts and the types of health care services utilized and their costs.

The reduction of income and the loss of health benefits remains a problem,

however, because of the temporary and time-limited nature of Section 1619. SSDI beneficiaries currently have no similar income protection, and their medical benefits are currently limited to three years after the onset of gainful employment. The problem is severe because few employers provide health insurance coverage for preexisting conditions, and many employers provide no health insurance coverage at all.

C. Private Health Insurance Is Not Available to Many People with Disabilities

Some disabled workers are forced into income support programs primarily because they cannot obtain private medical insurance coverage because of preexisting conditions. Persons with disabilities who are self-employed often have great difficulty becuase they rarely have access to a group insurance program. Furthermore, many small businesses that offer the low paying jobs held by many people with disabilities offer no medical coverage at all. For instance, in recent testimony (1985) before Congress, William H. Ashe, the Director of an Adult Developmental Disabilities Program in Barre, Vermont, reported that of 67 different paying positions held by disabled individuals in his program, only 19% offered Medical benefits, and only 10% full benefits. This experience is not unique to Vermont.

Eight States, including Wisconsin and Connecticut, currently sponsor high risk medical insurance pools for individuals who cannot otherwize obtain medical insurance. However, these pools are costly and provide protection primarily against catastrophic illnesses.

Consider the costs of insurance with different deductibles under Connecticut's high risk pool (data provided by Jack Hoadley, Legislative Assistant to U.S. Rep. B. Kennelly, 11/04/1985):

Age & Sex Category	Annual Deductible	Quarterly Premium	Maximum Annual Cost
Male, >age 30	$1500	$ 90.84	$1863.36
Female, age 50	$1000	$376.00	$2504.00
Female, age 50	$1500	$293.00	$2672.00
Female, age 60	$ 400	$800.00	$3600.00
Female, age 60	$1500	$450.00	$3300.00

The maximum annual cost includes the deductible and four quarterly premiums. In general, the pools do not cover persons over age 65, since they are usually eligible for Medicare. These data indicate that the risk pool does not provide a realistic alternative for individuals with low incomes or those with medium incomes who have high disability-related work expenses. The high risk pool, when

available, does meet the medical insurance needs of individuals with comparatively high incomes. State government support for the development of such pools suggests that States might lead the way in the development of cost-effective methods of meeting the health insurance needs of uninsured disabled persons with low incomes. Federal incentives (or demonstration funds) could stimulate more innovation at the State level.

To support the independence and self-sufficiency of persons with disability, health insurance should provide the coverage for the following services:

- o In-home and community-based care (and avoid insitutional care)
- o Preventive care, including early intervention and the prevention of secondary disabilities
- o Rehabilitation services to support return to work and maximum independence
- o "Wrap-around" coverage for eligible persons with inadequate health insurance coverage.

D. The SSI or SSDI recipient Who Returns to Work Loses the Income Security Associated with SSI and SSDI

Both disabled and nondisabled people are often as much concerned about the security of their income as they are about the amount. They will sometimes forego higher paying jobs in favor of those that are protected by seniority, tenure, civil service or other means. Beneficiaries of public support often have little incentive to exchange a secure source of monthly income for employment that reduces or adds little to net income.

Congress attempted to reduce the fear of loss of income security by providing a 15 month reentitlement period following the trial work period for both SSDI and SSI beneficiaries. However, this does not resolve the problem because severely disabled people often face an unreceptive job market. In general, people with disabilities receive lower pay and experience more

difficulty in locating jobs than their nondisabled counterparts. As a result, they experience more intermittant and underemployment than the general population.

E. Other Related Problems that Discourage SSI and SSDI Recipients from Working

The issues described below are treated in more detail by other Topic Papers prepared by the Council. They are included here because they greatly affect the ability of disabled people to work independently within their communities.

1. The Public and Private Sectors Offer Limited Employment Opportunities to Disabled People. Employer attitudes keep many disabled people out of the workforce. Many employers will not hire someone with a medical history of cancer or a disability regardless of their current medical condition. Modifications, such as adding a ramp and minor modifications to make an accessible work station for a physically disabled individual, or simplifying a task to make it consistent with the abilities of a developmentally disabled individual, requires an effort that frequently is not made.

2. Absence of a Continuum of Vocational Services. In most States the State rehabilitation agency is limited to providing initial, short-term funding for employment-related services. This service usually includes case management. In general, there is no Federal source of funding for long term or intermittent vocational services other than sheltered workshops. As a result, such services often are not available in many communities.

The lack of cross-agency coordination in some States and communities further complicates the problem. For instance, on occasion a person is determined ineligible for SSI or SSDI benefits because he or she does not meet the standards for disability payments and is simultaneously found ineligible for vocational

rehabilitation services because there is little or no reasonable expectation that employment would result from receiving services. In some States sheltered employment is an option; in others, the individual may completely "fall through the cracks."

3. Low Cost Accessible Transportation is Not Available in Some Communities; Accessible Vocational and Medical Special Transportation Services Often Stop when Other Benefits Cease. Severely disabled people may lack the transportation they need to move into the integrated competitive market place. If public transportation is available and accessible, it meets this need. However, if accessible public transportation is not available to the work site, the cost of other transportation may remove low paying jobs from consideration. State agencies (vocational rehabilitation, mental retardation and developmentally disabled) usually pay for or provide special transporation for their clients during the time they are receiving services, but this assistance stops when the client enters unsupported competitive employment. In a limited but unknown number of communities, other funding sources provide some transportation assistance.

4. An SSI or SSDI Recipient who Returns to Work Often Loses Access to Supported or Accessible Living Arrangements. The absence of affordable, accessible housing and alternative housing arrangements (group homes, supervised apartments) in many communities presents an insurmountable barrier to many disabled people. In some instances individuals who earn above certain limits lose their eligibility to live in a group home. The problem is acute because accessible housing is often unavailable at the cost and level of accessibility and supervision needed (NADCC, 1985, p. 43-44). Physically disabled persons often have great difficulty locating affordable, accessible housing, since nearly all such housing is located in federally subsidized Section 8 housing, which

requires a means test for occupancy.

IV. CASE STUDIES

Three case studies are presented below. Two are success stories associated with Section 1619; the other demonstrates the work disincentive that results when a person with severe disabilities who has vocational potential but no work experience is automatically eligible for income support payments.

A. John M.

John M. is a 35 year old man with a spinal cord injury due to an accident three years ago. He was divorced at the time of the accident; he is the father of two young children. John was employed before he became disabled as a skilled construction worker with an average yearly income of $30,000. He has a high school diploma and a vocational training program certificate in electrical and welding skills.

Today, John is physically dependent in all of his activities of daily living (e.g., cooking, housekeeping, shopping, and personal care needs such as bathing, grooming, and dressing). He uses an electric wheel chair and recently acquired a modified van with the assistance of vocational rehabilitation. John takes medication on a daily basis and requires ongoing medical supplies. To assist him with his every day personal care, John requires the services of personal attendants.

During his stay at City Rehabilitation Hospital in 1982, John was referred to the Massachusetts Bureau of Vocational Rehabilitation. His counselor arranged an assessment of John's functional and intellectional abilities and counseling in career goals. John had a strong desire to return to work, and his aptitude testing indicated that he would be a good candidate for computer training. With vocational rehabilitation funding, John attended a two year college and received an Associate of Arts degree in computer programming. Shortly before his

graduation, John received several offers from potential employers. Initially, John did not accept employment because he did not want to lose his medical benefits. However, his vocational rehabilitation counselor referred him to the Social Security Office and he obtained Section 1619 coverage. He then accepted employment because he could retain Medicaid coverage for his attendant care and other disability-related medical needs.

Currently John is employed at the Metropolitan Insurance Company as an entry level computer programmer. His employer installed a ramp and modified a work station to accommodate John's wheel chair. He has entered a Bachelor of Science program at a State university where he will study computer analysis. John is funding his continuing education with Metropolitan's employee benefit program and student loans.

Prior to employment, John received SSDI income benefits of approximately $600 per month and, through a "spend down," became a recipient of Medicaid. Now that he is working, John no longer receives SSDI income--instead, he pays taxes and contributes to the local economy. Under Section 1619, John continues to receive Medicaid benefits for disability-related expenses.

B. Rachel S.

Rachel S. is a 50-year-old woman who is multiply-disabled due to cerebral palsy and mental retardation. Rachel had been placed in a State institution at the age of five when her parents could no longer care for her; she has no functional math or reading skills. Five years ago, Rachael told her Department of Mental Health service coordinator that she wanted to leave the institution. Her service coordinator referred her to her local independent living center. There Rachel received independent living skills training and participated in a transitional living program for three years before moving into an independent

living arrangement in her community.

Rachel is physically dependent on assistance for all of her daily living and personal care needs and uses a wheelchair for mobility. She receives support in managing her finances and some other aspects of her personal life from an environmental support specialist provided by the Department of Mental Health.

Currently Rachel is employed in a supported work program. She shares an apartment with her roommate, Peggy, who has a similar background. Their skills are complementary; each helps the other to live independently in the community. Rachel receives Medicaid benefits through Section 1619 that pay her attendant care and disability-related medical needs.

The cost of institutional care for Rachel came to approximately $60,000 per year. She now earns about $3.50 per hour for an annual income of $7,000. Her medical benefits (approximately $5,200), environmental support specialist assistance ($364), and housing subsidy ($7,121) total about $12,685 per year. This represents a savings of $47,315 over the cost of maintaining Rachel in an institution. In addition, Rachel now pays taxes and contributes in other ways to the local economy.

Rachel is successfully integrated into her community. She serves as a member of the Human Rights Council at the Department of Mental Health. Since becoming independent, a test of intelligence showed that Rachel had gained 10 points. Best of all, Rachel states that she has a much happier life today.

C. Laura

Laura is a beautiful 15-year-old who has been deaf since birth. For the first five years of her education, she attended a State school for the deaf. At ten, she was "mainstreamed" into a community school and provided with a full-time interpreter who accompanied her to all classes and school events. So far, the

message from her government is: with a good education, you can become self-supporting. The funds we invest in your education will save large sums of money since we will not have to support you for life. In large part, due to the integration and interpreting support, Laura did well in school. She was on her way.

At 14, Laura became eligible for Supplemental Security Income because she was deaf. Checks began arriving at her home monthly and Medicaid paid for much of her medical care. The government now sent Laura this message: you are entitled to government aid.

For Laura, the checks seemed inordinately large. Because she did not have to pay for her housing, transportation, food or other daily living expenses, the subsidy was in fact a large one. At first, there was little effect on Laura or her family. Soon, however, both she and her divorced mother (who received Aid to Families with Dependent Children payments) began to depend upon the monthly checks.

Within six months, Laura had changed. She was absent from school more often. Her grades slipped precariously and she was placed on academic probation. In the classroom, she often engaged her interpreter during class lectures in private, signed conversations about boys, clothes, and makeup. Within one year, she had become a "D" student with no motivation even to complete high school. She no longer talked about going to college and becoming a teacher. As Laura told her interpreter one day at lunch: "Why study? I'm set for life."

Maintaining Laura on unneeded, dependency-creating disability income payments throughout her lifetime will cost this nation's tax payers many thousands of dollars and will yield no return on our investment in her education.

V. COSTS AND BENEFITS

The case studies in the previous section suggest that considerable savings can be realized by removing the disincentives to work in current programs. Although there is no accurate method of estimating costs and benefits associated with the permanent extension of Section 1619, the Congressional Budget Office has informally estimated that no increases in costs are associated with its permanent extension.

Others have projected considerable cost savings. For instance, in August of 1984, 6,000 SSI recipients earned over $713 a month, the break even point for going off of SSI payments. If permanent, continued Medicaid coverage encouraged these individuals to leave the SSI program, a savings of $324 a month per individual in SSI payments would result, or a projected reduction in cash benefits of $23 million per year (Bartlett, 1985).

The Adult Developmental Disablities Program in Vermont (Ashe, 1985) reports employment experiences that support these estimates:

> Since April of 1980, we have assisted 46 different individuals in becoming employed. Had these persons participated in the day treatment center which was available to them at the rate of $20 per day, rather than working in a competitive job, it would have cost $330,890 in Medicaid reimbursements. That figure in and of itself is nearly equal to the total cost of the job placement program which assisted them in becoming employed. In addition to this obvious benefit, the cash payment portion of these worker's SSI benefits have been reduced by $31,577 as a result of this increased earning power. Beyond these direct savings, however, these individuals have been offered the opportunity to participate fully in our economy, rather than continuing to depend on that economy because of the participation of others. In fact, these 46 persons have earned within the competitive job market $288,757 in wages, and have contributed taxes from these earnings in the amount of $32,977. Without question, these persons have moved from a position of nearly total dependency on government-sponsored programs to one of being largely independent of government for their existence.

In a 1985 study, a Napa/Sonoma California SSI/SSDI Task Force calculated estimated savings in income cash benefits had Section 1619(a) & (b) been in place in a local workshop for the last 10 years. The Task Force found that:

> Prior to the existence of Section 1619, individuals working in sheltered workshops and work activity centers often quit their employment when they received notice from Social Security that they would lose their cash and medical benefits due to their earnings from working. In 1979, individuals with IQ's of 69 or less and persons diagnosed with chronic schizophrenia were understandably frightened when their $379 monthly SSI cash and medical benefits were threatened by workshop earnings of $280. One has to be extremely handicapped not to realize that $379 with medical benefits is better than $280 with no medical beneifts. Since 1975, and prior to the existence of 1619(a)&(b) in 1980, a work activity center examined by the Task Force Committee had 25 SSI recipients quit employment rather than lose their SSI benefits. If they had remained in the work activity center, Social Security cash benefits would have been reduced by a very conservative $300,000 over ten years (i.e., $100 reduction x 25 individuals x 12 months x 10 years).

Assuming that 1,000 work activity centers experienced a similar situation, a savings to the taxpayers of $300 million over a 10 year period would result. The Task Force examined a work activity center that employs 180 severely and permanently disabled individuals. In the last six months, four of these individuals quit work or cut back the number of hours they worked in order to earn less than $300 a month and retain their SSDI. In the Committee's opinion, if they received vocational training many of these individuals should be capable of earning more than $300 a month. However, $300 would not be enough to meet their medical and living expenses.

As part of the same study, the Task Force obtained data on the effectiveness of Section 1619 from Napa Valley P.S.I., Inc. PSI is a work activity center located in Napa, California. In January of 1985, PSI saved the Social Security Administration $8,362 over a five week period. It did so by providing work (resulting in paid income) to 163 severely and permanently disabled individuals

who earned enough to reduce their SSI benefit payments by $8,362 over a five week period. The Task Force calculated that these savings would result in an annual savings to SSI of $86,965, as follows: $8,362/5 wks. = $1,672/wk x 52 wks = $86,965.

The Task Force projected these savings on a national scale by estimating the savings if each of the 225,017 disabled workers in the 4,814 work activity centers and workshops certified by the Department of Labor in September, 1984 showed similar savings. The average savings per individual in the PSI workshop is $534 ($86,965/163 disabled workers). National savings on an annual basis would be $120 million ($534 x 225,017 disabled workers). This, the Task Force submits, represents a substantial savings.

Savings to the government can result from innovative methods under current programs. The Chapter 599 program in Massachusetts makes special status Medicaid benefits available to severely disabled people who could not afford to work without medical benefits. Based on its follow-up of 91 clients, the Massachusetts Rehabilitation Commission (personal communication with analyst, July, 1985) calculates that it saved taxpayers $408,670 in 1984, calculated as follows:

Income Taxes Paid:	Federal	$134,000
	State	58,000
SSI Payments not made		33,670
Client contributions on a sliding scale for attendant services		143,000
	Total Saved	$408,670

The benefits to society are even greater if individual benefits, such as increases in self-esteem and mental and physical health, and economic benefits to the community such as purchase of goods and services are considered. Assuming that comparable numbers of SSI beneficiaries would be encouraged to work in every

State, 4,732 individuals (52 States x 91 persons) would benefit from the permanent extension of Section 1619 for a national savings of approximately $21.25 million (52 x $408,670).

VI. RECOMMENDATIONS

The income and medical benefit programs authorized under the Social Security Act provide many severely disabled people with basic life necessities. However, some Federal programs under current Social Security laws not only fail to promote employment and independence for citizens with disabilities, but actually penalize and discourage people with disabilities if they become employed. The Council believes that the multibillion dollar expenditure for these programs--Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid and Medicare--would be reduced if the programs were modified to reflect the ability of many severely disabled people to become gainfully employed. The programs should assure that people with disabilities who work have access to medical insurance and that individuals who begin working while receiving benefits from Federal income support programs increase their income.

Currently the Social Security Administration's (SSA) process for determining eligibility for SSI or SSDI income benefits begins with a medical evaluation of the individual's disability. Only in cases in which the disabilty is not on the SSA "medical list" (e.g. blindness, deafness, spinal cord injuries) does the eligibility determination include both a medical diagnosis and an assessment of vocational potential. This determination process can sometimes result in the automatic award of benefits to individuals with clearly defined medical disabilities who have significant vocational potential and should be able to work. A major disincentive to work for many current SSI and SSDI recipients is that employment in many entry level and low paying service jobs will often result in reduced income and the loss of medical and other benefits. The Council also finds evidence that many people with preexisting medical conditions cannot obtain adequate health insurance at an affordable cost. This problem creates an

incentive to enter public aid programs since the medical costs associated with some disabling and preexisting conditions exceed the working individual's ability to pay.

1: Congress should amend the Social Security Act to make eligibility for SSI and SSDI programs dependent upon the presence of a severe medical disability and a functional assessment to determine vocational potential whenever deemed appropriate.

Whenever the vocational potential of a working age applicant is at issue, applicants who are not terminally ill should be required to undergo a functional vocational assessment that establishes that they will have substantial difficulty working because of severe vocational limitations of an ongoing nature. Individuals with disabilities who are refused SSI and SSDI income support benefits because they are determined to be able to work should be offered vocational rehabilitation services.

This recommendation is designed to change the focus of disability determination from a purely medical standard to one that assesses the full range of factors that affect the ability to work of persons with disabilities. It narrows the definition prevent those who have a medical impairment but the ability to work from automatical becoming eligible for income support benefits.

To implement this recommendation, the Social Security Administration should be charged with developing procedures for conducting functional vocational assessments and for assuring that adequately trained people are available to carry out the assessments. For instance, SSA could contract for this service with independent agencies, such as independent living centers, vocational rehabilitation agencies, or colleges and universities. SSA should also enter into cooperative agreements with State vocational rehabilitation agencies to assure that individuals who are refused benefits because of their vocational potential are not then refused vocational

rehabilitation services. Applicants should not be required to undergo a second, duplicative vocational assessment if they are referred to vocational rehabilitation for services.

2. Congress should amend the Social Security Act to assure that SSI and SSDI recipients who become gainfully employed are permitted to retain benefits and have access to medical insurance in circumstances where the loss of such benefits would substantially negate the income they might earn.

Three steps should be taken to implement this recommendation. First, Section 1619(a)&(b) of the Social Security Act, which authorizes continuing cash benefits and Medicaid coverage to working SSI beneficiaries, should be made permanent, thereby removing the uncertainty associated with the temporary nature of Section 1619.

Second, Section 1619 provisions should be extended to SSDI recipients. The formula for determining benefits when earnings increase may need to be modified since some SSDI recipients receive comparatively high benefit payments. If the same Federal break-even point used for SSI were used for SSDI, benefits might reach inappropriately high levels.

Third, Medicare and Medicaid coverage should be made available on a sliding fee scale that reflects income to working SSDI and SSI beneficiaries who cannot obtain private health insurance coverage because of their disabilities. Employers should be required to contribute an amount equal to that contributed to other employee health insurance plans. Alternatively, cooperative programs with insurance programs might be developed in which Medicaid pays disability-related medical expenses and the private insurer would be responsible for other medical expenses.

3. Congress should direct the Health Care Financing Administration to study and recommend cost-effective methods for providing health insurance coverage to persons with preexisting conditions who cannot obtain adequate health insurance coverage from private insurers at affordable rates. The study should be conducted in consultation with the National Council on the Handicapped and findings and recommendations should be reported in hearings before Congress within two years of the date of enactment of this provision.

Some disabled workers are forced into income support programs primarily because they cannot obtain private medical insurance coverage due to the preexisting conditions of diabilitiy. Persons with disabilities who are self-employed often have great difficulty because they rarely have access to a group insurance program. If a disabled worker's income is not sufficient to cover both basic living and medical expenses, the worker may be forced into a public assistance program in order to obtain the needed medical benefits.

The Council believes that the availability of health insurance coverage for people with disabilities is an important incentive to employment, and that the States may be able to provide leadership in this area. Innovative programs in place in those States that provide health insurance coverage for uninsured populations should be examined, and a variety of funding and insurance strategies should be considered.

Considerable savings can be realized by removing the disincentives to work in current programs: Medicaid benefit payments often decrease when a person with a disability is employed. Income support payments will always be reduced as recipients of income benefits become gainfullly employed and income support benefits are reduced or ended. Although there is no precise method of estimating costs and benefits, the Congressional Budget Office has informally estimated that no increases in costs are associated with a permanent extension of Section 1619. Other authorities have projected considerable cost savings. For instance, in August of 1984, 6,000 SSI recipients earned over $713 a month, the break-even

point for going off SSI payments. If permanent, continued Medicaid coverage encouraged these individuals to leave the SSI program, a savings of $324 a month per individual in SSI payments would result in a projected reduction in cash benefits of $23 million per year (Bartlett, 1985). The advantages to society are even greater if individual benefits, such as increases to self-esteem and mental and physical health, and economic benefits to the community, such as the purchase of goods and services, are considered.

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